The Protection

HMO Blue p.1

When you have HMO Blue, you have the comfort of knowing you're covered in sickness, in health, in the hospital, and in emergencies. You have benefits with no waiting periods, no deductibles, virtually no claim forms, and minimal out-of-pocket expense. And, in case of an emergency, you have Blue Cross Blue Shield's immediate name recognition wherever you travel.

COVERED SERVICES†	YOUR COST
Outpatient Care	
Office visits	$5 per visit
Well-child care	$5 per visit
Routine checkups (including one gynecological exam per calendar year)	$5 per visit
Emergency room visits	$25 per visit
Maternity care	No charge
Allergy injections only	No charge
X-rays, laboratory tests, and other imaging tests	No charge
Oxygen and equipment for its administration	No charge
Hearing exams	$5 per visit
Routine vision exams (one exam per calendar year)	$5 per visit
Family planning and infertility services	$5 per visit
Preventive dental care for children under age 12 (one visit each six months)	No charge
Home health care, including hospice care	No charge
Durable medical equipment (such as wheelchairs, crutches, hospital beds) and repairs: Covered up to a maximum of $1,500 per calendar year (waived if provided as part of a home health care program)	Charges beyond the $1,500 benefit maximum
Short-term rehabilitative therapy - physical, speech/language, or occupational (up to 60 consecutive days per condition)	$5 per visit
Prosthetic devices	20% of approved charges
Mental Health and Substance Abuse Treatment	
Biologically-based conditions*	
Inpatient admissions in a general hospital or mental hospital	No charge
Outpatient visits	$5 per visit
Non-biologically-based mental conditions (includes drug addiction and alcoholism)	
Inpatient admissions in a general hospital	No charge
Inpatient admissions in a mental hospital or substance abuse treatment facility (up to 60 days per calendar year)	No charge
Outpatient visits (up to 24 visits per calendar year)	$5 per visit
Alcoholism treatment (in addition to non-biologically-based mental conditions)	
Inpatient admissions in a general hospital	No charge
Inpatient admissions in a substance abuse treatment facility (up to 30 days per calendar year)	No charge
Outpatient visits (up to 8 visits per calendar year)**	$5 per visit
Prescription Drug Benefit	
At participating retail pharmacies (up to a 30-day supply for each prescription/refill or supply)	$10 for generic†† $20 for preferred brand-name $35 for non-preferred
Through mail-service drug program (up to a 90-day supply for each prescription/refill or supply)	$10 for generic†† $20 for preferred brand-name $35 for non-preferred

† Any visit, day, or dollar maximums may be reduced by any benefits provided in the same calendar year under prior Blue Cross and Blue Shield plans as allowed by state law.

* Treatment for rape-related mental or emotional disorders and treatment for children under age 19 is covered to the same extent as biologically-based conditions.

** The value of these visits is at least $500 in each calendar year.

†† In a few instances, a generic drug or supply may be covered as a non-preferred drug. If you have questions about which copayment applies, ask your pharmacist or call Customer Service at 1-800-782-3675.

COVERED SERVICES†	YOUR COST
Inpatient Care Hospital care (as many days as medically necessary)	No charge
Semiprivate room and board	No charge
Surgical services, X-rays and laboratory tests, and anesthesia	No charge
Drugs and medications	No charge
Physicians' services	No charge
Maternity care	No charge
Intensive care services	No charge
Care in a skilled nursing facility (up to 100 days per calendar year)	No charge
Care in a rehabilitation facility (up to 60 days per calendar year)	No charge

Urgent Care. This is care needed to treat an urgent medical condition that can wait for the time it takes to call your PCP for advice. Examples of urgent care are sprains, earaches, and high fever. If you need urgent medical care, call your PCP to arrange where you'll receive treatment. All HMO Blue PCPs have 24-hour phone coverage, seven days a week.

Emergency Room Services. In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call 911 (or the local emergency phone number). There is a $25 copayment for emergency room services, which is waived if your stay is for observation or you're admitted to the hospital. You or someone on your behalf must call your PCP within 48 hours. Any follow-up care must be arranged by your PCP.

When Outside the Service Area. If you're traveling outside the plan service area and you need urgent or emergency care, you may go to the nearest appropriate health care facility. You are covered for the urgent or emergency care visit and one follow-up visit. You or someone on your behalf must call Customer Service within 48 hours. Any additional follow-up care must be arranged by your PCP.

Dependent and Student Benefits. HMO Blue covers your unmarried dependent children until age 19, or full-time students until age 26. Student coverage ends when the student turns 26, or marries, or on November 1 following the date the student discontinues full-time classes or graduates, whichever comes first.

The Care

With our extensive network of health care professionals, you can expect to receive only the finest care from HMO Blue.

Your Primary Care Physician. Your primary care physician (PCP) is the first person you call when you need medical care. If your PCP determines that you need to see a specialist, you'll most likely be referred to a specialist affiliated with your PCP's hospital or group practice. This is because your PCP has a working relationship with these specialists. And, the fact that your PCP and your specialist can easily communicate helps to ensure the quality of your care.

Referrals You Can Feel Better About. The bottom line for your HMO Blue PCP is your health. Which is why, should you and your PCP decide you need a specialist, you'll be referred to the one your physician determines is appropriate for treating your specific condition. It will be a specialist your physician knows well - probably someone affiliated with the same hospital or medical group - so that your latest charts, X-rays, and test results are never out of reach. And, most importantly, it will be a specialist your physician knows can be trusted to give you quality care. Of course, if you have a specialist to whom you would like to be referred, tell your doctor. It's an important decision and the top priority is always getting you healthy again.

Choosing a Primary Care Physician. When you join HMO Blue, you choose a PCP for you and each member of your family. You'll find a complete listing of our PCPs in the HMO Blue Directory of Providers. In addition to PCPs, the directory lists specialists and hospitals. If you don't have a copy of the directory, call our Physician Selection Service at 1-800-821-1388 and we'll send you one right away. If you have trouble choosing a doctor, the Physician Selection Service can help. We can tell you whether a doctor is male or female, the medical school(s) he or she attended, and if any languages other than English are spoken in the office.

VIP 2000 PLAN P. 1

You Are Free to Choose

With VIP 2000, you may use any Blue Cross Blue Shield participating provider in the United States. In Massachusetts, all general hospitals and most physicians participate with Blue Cross Blue Shield. There are no claim forms for services you receive in Massachusetts by a participating provider. With VIP 2000 there are reasonable out-of-pocket expenses. And, your plan gives you nationwide access to participating hospitals, medical, surgical, and other health care providers. Here's a summary of VIP 2000 benefits.

COVERED SERVICES†	YOUR COST
Physicians', chiropractors', and podiatrists' office visits	$15 per visit
X-rays, lab tests, and other tests, including routine Pap smears and mammograms	
• Office or health center	$15 per visit
• Hospital, independent lab, or free-standing diagnostic imaging facility	20% co-insurance
Short-term rehabilitation therapy:	
• Office or health center	$15 per visit
• Hospital outpatient department	20% co-insurance
Speech, hearing and language disorder treatment:	
• Office or health center	$15 per visit
• Hospital outpatient department	20% co-insurance
Routine pediatric care according to age-based schedule until the child turns age 19	$15 per visit
Routine adult physical exams according to age-based schedule	Charges over the $75 allowance
Maternity care in a doctor's office or health center	One $15 copayment covers all prenatal care
Hospital outpatient department services (including maternity care and allergy injections)	20% co-insurance
Home health care and hospice care	20% co-insurance
Durable medical equipment (such as wheelchairs, crutches, hospital beds)	20% co-insurance
Inpatient Care (including maternity care)	
Care in a general, chronic disease, or rehabilitation hospital (for as many days as medically necessary)	Nothing
Physicians' services	Nothing
Care in a skilled nursing facility (up to 100 days per calendar year)	Nothing
Outpatient Emergency Care	
Hospital emergency room	20% co-insurance
Professional provider and health center services	$15 per visit
Mental Health and Substance Abuse Treatment	
Biologically-based conditions*	
Inpatient admissions in a general or mental hospital	Nothing
Outpatient hospital visits	20% co-insurance
Outpatient professional provider and health center visits	$15 per visit
Non-biologically-based mental conditions (includes drug addiction and alcoholism)	
Inpatient admissions in a general hospital	Nothing
Inpatient admissions in a mental hospital or substance abuse treatment facility (up to 60 days per calendar year)	Nothing
Outpatient visits (up to a combined maximum of 24 visits per calendar year)	
Hospital visits	20% co-insurance
Professional provider and health center visits	$15 per visit
Alcoholism treatment (in addition to non-biologically-based mental conditions)	
Inpatient admissions in a general hospital	Nothing
Inpatient admissions in a substance abuse treatment facility (up to 30 days per calendar year)	Nothing
Outpatient visits (up to a combined maximum of 8 visits per calendar year)	
Hospital visits	20% co-insurance
Professional provider and health center visits	$15 per visit

† Any visit, day, or dollar maximum may be reduced by any benefits provided in the same calendar year under prior Blue Cross Blue Shield of Massachusetts plans.

* Treatment for rape-related mental or emotional disorders and treatment for children under age 19 is covered to the same extent as biologically-based conditions.

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COVERED SERVICES†	YOUR COST
Prescription Drug Benefit At designated retail pharmacies: (up to a 30-day formulary supply for each prescription/refill or supply)	$10 for generic†† $20 for preferred brand-name $35 for non-preferred
Through mail-service drug program: (up to a 90-day formulary supply for each prescription/refill or supply)	$10 for generic†† $20 for preferred brand-name $35 for non-preferred

† Any visit, day, or dollar maximum may be reduced by any benefits provided in the same calendar year under prior Blue Cross Blue Shield of Massachusetts plans.

†† In a few instances, a generic drug or supply may be covered with a copayment other than the lowest copayment level. If you have questions about which copayment applies, ask your pharmacist or call Member Service.

Living Healthy® Programs

Your VIP 2000 membership helps you live as healthy a life as possible. Call us at 1-800-782-3675 and we'll send you our booklet *Living Healthy Programs*, which outlines how to take advantage of many special programs available to you. Here's a summary of the programs.

LIVING HEALTHY *Babies*®	No charge
Living Healthy Vision—discounts on eyewear (frames, lenses, supplies and laser vision correction surgery)	Discount varies
Blue Care® Line to answer your health care questions 24 hours a day—call **1-888-247-BLUE (2583)**	No charge
Living Healthy Naturally—discounts for acupuncture, massage therapy, and nutritional counseling	20% discount
Visit www.AHealthyMe.com for an around-the-clock healthy approach to fitness, family, and fun	No charge
Member Self Service on www.bluecrossma.com—to help you manage your health care	No charge

More About The Plan

When Coverage Begins. Coverage is available immediately upon enrollment for all covered services.

Co-insurance Maximum. You pay 20% co-insurance for hospital outpatient services and a $15 copayment for professional provider or health center services. When the money paid for the 20% co-insurance equals $1,000 for a member in a calendar year (or $2,000 for all family members covered under the same membership), full coverage, based on the allowed charge, is provided for the remainder of that calendar year. Your copayments do not count toward your co-insurance maximum. If you reach your co-insurance maximum you must still pay your copayment when it applies.

Lifetime Maximum. Each member has a $2 million lifetime benefit maximum for all covered services. (If you change from one Blue Cross Blue Shield of Massachusetts plan to another, any dollar amount applied toward your lifetime maximum under prior Blue Cross Blue Shield of Massachusetts plans will be carried over and applied to the lifetime maximum under this plan.)

Dependent and Student Benefits. VIP 2000 covers your unmarried dependent children until age 19, or full-time students until age 26. Student coverage ends when the student turns 26, or marries, or on November 1 following the date the student discontinues full-time classes or graduates, whichever comes first.

Utilization Review Requirements. You must follow the requirements of Utilization Review, which are Pre-Admission Review, Concurrent Review and Discharge Planning, and Individual Case Management. Information concerning Utilization Review is detailed in your benefit description. If you need non-emergency or non-maternity hospitalization, you, or someone on your behalf, must call the number on your ID card for pre-approval. If you do not notify Blue Cross Blue Shield and receive pre-approval, your benefits may be reduced or denied.

See back page for information about participating providers.

Medex p1

Inpatient Care	Medicare Provides	Medex Provides
Hospital care–including surgical services, X-rays and laboratory tests, anesthesia, drugs and medications, and intensive care services	•Coverage for days 1–60 per benefit period after $876 inpatient deductible •Coverage for days 61–90 after $219 daily co-insurance •Coverage for an additional 60 lifetime reserve days after $438 daily co-insurance	•Full coverage of Medicare deductible and co-insurance •Full coverage of lifetime reserve day co-insurance •Full coverage up to 365 additional hospital days in your lifetime when Medicare benefits end*
Physician or other professional provider services	80% of approved charges after $100 annual Part B deductible	Full coverage of Medicare deductible and co-insurance
Skilled nursing facility–participating with Medicare	•Full coverage for days 1–20 •Coverage for days 21–100 after $109.50 daily co-insurance	•Full coverage of Medicare daily co-insurance for days 21–100 •$10 daily for days 101–365
Skilled nursing facility–not participating with Medicare**	No benefits	$8 daily for 365 days per benefit period
Outpatient Care		
Office visits Accident treatment Sudden and serious medical emergency treatment Surgery Radiation therapy X-ray and laboratory tests Podiatrists' services Hemodialysis Ambulance services Durable medical equipment Cardiac rehabilitation services Physiotherapy services	80% of approved charges after $100 annual Part B deductible	Full coverage of Medicare deductible and co-insurance
Retail prescription drugs–administered by Express Scripts	Medicare does not provide coverage for most prescription drugs used outside of the hospital. See your Medicare handbook for certain covered drugs.	After a $35 calendar-quarter deductible: •Full coverage (generic drugs) •80% coverage (brand-name drugs) Purchased at participating pharmacies inside Massachusetts or any pharmacy outside of Massachusetts.
Mail-service drugs–administered by Express Scripts	No benefits	Full coverage after a: •$2 copayment (generic drugs) •$15 copayment (brand-name drugs) Up to a 90-day supply–generic or brand-name, when purchased from the mail-service pharmacy.
Blood glucose monitors and and materials to test for the presence of blood sugar	80% of approved charges after $100 annual Part B deductible for all diabetics	Full coverage of Medicare deductible and co-insurance
Urine test strips Claims must be submitted on a Medex Subscriber Claim Form.	No benefits	Covered to the same extent as brand-name prescription drugs.

* The 365 additional days per lifetime are a combination of days in a general or mental hospital.
** A combined maximum of 365 days per benefit period in a Medicare-participating and non-participating skilled nursing facility.

Outpatient Care	Medicare Provides	Medex Provides
Chiropractor services	80% of approved charges after $100 annual Part B deductible, for manual manipulation of the spine to correct a subluxation demonstrated by an X-ray	Full coverage of Medicare deductible and co-insurance for Medicare-approved charges only
Mental Health and Substance Abuse Treatment		
Biologically-based mental health conditions*		
Inpatient admissions in a general or mental hospital	• Coverage for days 1–60 per benefit period after $876 inpatient deductible • Coverage for days 61–90 after $219 daily co-insurance • Coverage for an additional 60 lifetime reserve days after $438 daily co-insurance • Coverage for mental hospital admissions is limited to 190 days per lifetime	• Full coverage of Medicare deductible and co-insurance • Full coverage of lifetime reserve day co-insurance • Full coverage up to 365 additional hospital days in your lifetime when Medicare benefits end**
Outpatient visits	Full coverage after $100 annual Part B deductible and Part B co-insurance	• When covered by Medicare, full coverage of Medicare deductible and co-insurance with no visit maximum • When visits are not covered by Medicare, full coverage with no visit maximum
Non-biologically-based mental health conditions (includes drug addiction and alcoholism)		
Inpatient admissions in a general hospital	• Coverage for days 1–60 per benefit period after $876 inpatient deductible • Coverage for days 61–90 after $219 daily co-insurance • Coverage for an additional 60 lifetime reserve days after $438 daily co-insurance	• Full coverage of Medicare deductible and co-insurance • Full coverage of lifetime reserve day co-insurance • Full coverage up to 365 additional hospital days in your lifetime when Medicare benefits end**
Inpatient admissions in a mental hospital	Same coverage as a general hospital, but coverage is limited to 190 days per lifetime	• Full coverage of Medicare deductible and co-insurance • Full coverage of lifetime reserve day co-insurance • When Medicare days are used up, full coverage for 120 days per benefit period (at least 60 days per calendar year), less any days in a mental hospital already covered by Medicare or Medex in that benefit period (or calendar year)
Outpatient visits	Full coverage after $100 annual Part B deductible and Part B co-insurance	• When covered by Medicare, full coverage of Part B deductible and co-insurance with no visit maximum • When not covered by Medicare, full coverage up to 24 visits per calendar year

* Treatment for rape-related mental or emotional disorders is covered to the same extent as biologically-based conditions.

** The 365 additional days per lifetime are a combination of days in a general or mental hospital.

Dental Blue®

Preventive Benefit Group	Basic Benefit Group	Major Benefit Group	Orthodontic Benefit Group
No Deductible	**$25 Per Member/$75 Per Family Calendar-Year Deductible**	**No Deductible**	**No Deductible**
Full	**80%**	**50%**	**50%**
Diagnostic • One complete initial oral exam and charting • Full mouth X-rays each 60 months, seven or more films, or panoramic X-rays with bitewing X-rays • Bitewing X-rays each six months • Single tooth X-rays as needed • Study models and casts each 60 months • Periodic or routine oral exams each six months • Emergency exams when the dentist does not perform another covered service during the visit Preventive • Routine cleaning, scaling, and polishing of the teeth each six months • Fluoride treatment (members under age 19) each six months • Sealants on pre-molars and permanent molars (members under age 14), one application per molar each 48 months • Space maintainers (members under age 19)	Restorative • Silver amalgam fillings (limited to one filling for each tooth surface in a 12-month period) • Composite resin (tooth color) on front teeth (limited to one filling for each tooth surface in a 12-month period). The plan provides benefits for amalgam fillings towards the cost of composite resin (tooth color) fillings on back teeth. You pay any balance. • Sedative fillings • Pin retention for fillings • Stainless steel crowns on baby teeth and on first permanent adult molars (members under age 16) Oral Surgery • Tooth extraction • Root removal • Biopsies Periodontics (gum and bone) • Periodontal scaling and root planing once per quadrant each 24 months • Periodontal surgery (curettage, osseous surgery) once per quadrant each 36 months • Periodontal maintenance following active periodontal therapy once each three months Endodontics (roots and pulp) • Root canal therapy or retreatment root canal therapy once per lifetime per tooth on permanent teeth • Therapeutic pulpotomy (members under age 16) • Other endodontic surgery Prosthetic Maintenance • Repair of partial or complete dentures, crowns, and bridges once each 12 months • Adding teeth to an existing complete or partial denture • Rebase or reline of dentures once each 36 months • Recementing of crowns, inlays, onlays, and fixed bridgework once each 12 months Other Services • Occlusal adjustments once each 24 months • Services to treat root sensitivity • Emergency dental care • General anesthesia when administered in conjunction with covered surgical services	Prosthodontics (teeth replacement) • Complete or partial dentures (including services to fabricate, measure, fit, and adjust them) once each 60 months for each arch • Fixed bridges (including services to fabricate, measure, fit, and adjust them) once each 60 months for each tooth • Replacement of dentures and bridges once each 60 months • Adding teeth to an existing bridge • Temporary partial dentures to replace any of the six upper or six lower front teeth (only covered if they are installed immediately following the loss of teeth and during the period of healing) Major Restorative • Crowns, inlays, and onlays • Replacement of crowns, inlays, and onlays once each 60 months per tooth • Post and core or crown buildup once each 60 months per tooth	Orthodontics (Members to age 19) • Complete orthodontic exam • Comprehensive or limited active orthodontic treatment including appliances
$1,000 Calendar-Year Benefit Maximum			**$1,500 Lifetime Benefit Maximum**